Service Area Plan

Department of Health

Women's and Infant's Health Services (43005)

Service Area Background Information

Service Area Description

This service area seeks to improve the health of women and infants in the Commonwealth by assessing their needs, developing policies, building capacity and strengthening the infrastructure to meet these needs, and assuring that quality services are provided to this population. This is accomplished through resource development and allocation; program monitoring and evaluation; public and customer education; technical assistance, consultation and training; and provision of direct services.

Service Area Alignment to Mission

This service area directly aligns with the Virginia Department of Health's mission by improving the health of women across their lifespan, with particular concern for achieving healthy pregnancy outcomes and reducing the burden of infant mortality and morbidity.

Service Area Statutory Authority

§ 32.1-2 of the Code of Virginia charges the State Board of Health, the State Health Commissioner and the Virginia Department of Health to provide a comprehensive program of preventive, curative, restorative and environmental health services including education of the citizenry and developing and implementing health resource plans. Prevention and education activities focusing on women's health including but not limited to breast cancer and other conditions unique to or more prevalent among women are required.

§ 32.1-40 of the Code of Virginia requires every practitioner of the healing arts and every person in charge of any medical care facility to permit disclosure of medical records to the State Health Commissioner or his designee. Under the provisions of the Code the local health officer may obtain access to medical records for the purpose of public health investigation of fetal and infant deaths, or to investigate an illness for the purpose of disease surveillance.

§ 32.1-67 of the Code of Virginia requires the Board of Health to recommend procedures for the treatment of sickle cell diseases and provide such treatment for infants in medically indigent families.

§ 32.1-68 of the Code of Virginia requires the Commissioner of Health to establish a voluntary program for the screening of individuals for the disease of sickle cell anemia, sickle cell trait, and other genetically related diseases and genetic traits.

§ 54.1-2969 of the Code of Virginia states a minor shall be deemed an adult for the purposes of consenting to services related to birth control, pregnancy or family planning and the diagnosis and treatment of sexually transmitted disease.

The Breast and Cervical Cancer Early Detection Program (BCCEDP), called Every Woman's Life, operates under the Breast and Cervical Cancer Mortality Prevention Act of 1990, Public Law 101-354. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides payment of medical services for certain women screened by an authorized provider and found to have breast or cervical cancer under a federally-funded screening program. In 2001, Virginia amended the Code of Virginia § 32.1-325 to permit women who have been screened and diagnosed with breast or cervical cancer by an authorized BCCEDP provider to be enrolled in the state Medicaid program for payment of treatment services.

§ 18.2-76 of the Code of Virginia requires the Virginia Department of Health to make available to each local health department and upon request, to any person or entity, materials regarding the informed consent for abortion.

§ 20-142 of the Code of Virginia requires the Virginia Department of Health to provide every person who is empowered to issue a marriage license to distribute the following information to the applicants: birth control information, information concerning the role of folic acid in the prevention of birth defects, information on acquired immunodeficiency syndrome and a list of family planning clinics by city and county.

The federal grants administration procedures detailed in Title 43 of the Code of Federal Regulations (CFR), part 74 and the provisions of Title 42 of the CFR 431.300 and Attachment 4.3A of the Virginia State Plan for Medical Assistance, require safeguards for restricting the use or disclosure of information concerning Medicaid applicants and recipients. Compliance with these requirements is recognized to be an obligation of each participating department during all handling and every exchange of information with any other parties concerning eligibility, income, and other personal data of Medicaid applicants and recipients and under all other circumstances and regulations on the privacy of individuals.

Title V of the Social Security Act, Section 501 (42 USC 701) requires that the state agency administering the state's program will fulfill agreements to ensure coordination of care and services available under Title V and Title XIX. Title V grantees will also provide, directly and through providers and institutional contractors, services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

Title V of the Social Security Act (42 USC 701-709) also provides assurance that mothers and children, in particular those with low income or with limited availability of health services, have access to quality maternal and child health services including, but not limited, to efforts to reduce infant mortality and morbidity and the incidence of preventable diseases. It promotes the health of mothers and infants by providing prenatal, delivery and postpartum care.

Title X of the Public Health Services Act (42 U.S.C. 300, et seq.) provides funding for family planning agencies and is an outgrowth of the Family Planning Services and Population Research Act of 1970, P.L. 91-572. This law was amended in 1975 and 1978 to require Title X projects to provide access to natural family planning, infertility, and adolescent services. These amendments require that economic status not be a deterrent to receiving family planning services.

Service Area Customer Base

Customer(s)	Served	Potential
Community Providers including obstetricians, family practice physicians, pediatricians, nurses, nurse practitioners, public health officials, social workers, nutritionists and other allied health professionals	10,000	10,000
Divisions within VDH who serve women and infants	7	7
Family members of women and infants	211,100	211,100
Female Population in the Commonwealth (10 – 64 years old)	3,191,822	3,191,822
Governor and General Assembly	2	2
Local health departments	119	119
Men and women seeking contraceptive services in local health departments	80,000	371,640
Newborns and children with Sickle Cell Disease and Hemoglobinopathies	1,100	114,000
Number of women receiving prenatal care through local health departments	17,346	23,033
Other private organizations dealing with women and infant clients (e.g., People, Inc., INOVA, Teensight, Carilion Health System, ACS, VA Breast Cancer Foundation)	30	50
Pregnant women in the Commonwealth (including teens)	130,000	130,000
State agencies including academic medical centers who work with women and infants	10	20
Statewide provider and consumer organizations	70	150

Anticipated Changes In Service Area Customer Base

• Although the number of pregnant women varies from year to year, the overall number is projected to decline long-term but not in the next five years. Additionally, the overall birth rates remain relatively stable from 13.9 in 1996 to the current rate of 13.6 in years 2002 and 2003. VDH expects a slight increase due to immigration.

• Based on various data and analysis from the United States Census Bureau 1990 and 2000 reports, and the Virginia Center for Health Statistics 1996-2003, the overall percentage and age distribution of the female population has remained relatively constant since 1990. The annual growth rate from 2000-2004 of the overall Virginia population, per the Weldon Cooper Center, was 1.2 percent. Because females represent 51% of the overall Virginia population, it is estimated that the number women aged 10-64 will increase annually at a rate of 1.006 percent.

• Virginia ranks 17th in the nation with the largest immigrant resident population; 16th largest Hispanic and 9th largest Asian population in the country. Lack of interpreters and culturally competent providers will limit access to care and reduce the quality of care. The demand for health care and family planning services is expected to increase among a growing number of noncitizen residents who cannot afford health care in the private health care system and do not qualify for Medicaid.

• Fifteen percent of women receive prenatal care after the first trimester. Minorities, who may or may not also be immigrants, have much lower rates of prenatal care utilization, e.g. three out of ten Hispanic women enter prenatal care after the first trimester. Lower utilization often is due to lack of insurance coverage. It is expected there will be an increasing demand for prenatal care services by clients without any insurance or who are underinsured, placing more demands on nonprofit health care organizations.

• At the same time the number of Medicaid-eligible pregnant women, women 60 days postpartum, and infants from birth to two years of age who meet the definition of high-risk will increase due to the eligibility being expanded from 133 percent to 150 percent of poverty. Thus more very low income women will be become insured.

• Over the past fifteen years, the number of people who are overweight or obese has increased dramatically. Obesity is associated with complications of pregnancy and morbidity in women as they age. Low levels of physical activity contribute to poor health from heart disease, stroke, high blood pressure, diabetes, some cancers, and can contribute to symptoms of arthritis. Physical inactivity and unhealthy eating are two primary causes of obesity and are responsible for preventable deaths. The number of women with complications of pregnancy and delivery due to obesity is increasing and will demand more intensive, complicated and costly health care services.

• From 1900 to 1982, maternal deaths from pregnancy related complications declined dramatically. Since then, there has been no significant reduction, yet studies indicate that as many as one-half of all the deaths from pregnancy complications could be prevented. Prior to the 1980s, the causes of maternal deaths were hemorrhage, infection and pulmonary embolism. The causes of maternal deaths is shifting away from specific medical conditions to cardiovascular disease associated with drug usage, including tobacco and obesity, domestic violence, and homicide.

• Using the final 2000 census data, the Alan Guttmacher Institute found that 371,640 women, including 119,930 sexually active teenagers needing public-supported contraceptive services in Virginia. This is decreasing slightly but continues to surpass the capacity of VDH clinics. The most popular types of contraceptives are more expensive and local health departments cannot afford to offer them. Virginia is

already ranked in the bottom ten states in terms of availability of contraception, and funding is continuing to decline due to public sentiment that favors abstinence and discourages sexual activity.

• In 2003, 30.6 percent of all births were nonmarital. Of these, 60 percent were to women aged 20-29 years. The current trend is that nonmarital births are increasing. In 2004, the percentage of non-marital births increased to 31 percent with 70 percent of these being to women aged 20-29 years. The rate of African American non-marital births is 700 per 1,000 live births or 2 1/2 times that of the white non-marital births (300 per 1,000 births).

• Women die of cervical cancer at a rate of 3 per 100,000 women in Virginia; with early detection and treatment, no woman should have to die from cervical cancer. Human Papillomavirus (HPV) is a sexually transmitted organism that is associated with the development of cervical cancer. Cervical cancer along with other forms of sexually transmitted diseases is on the rise.

• In 2004, the infant mortality rate (death within the first year of life) was 7.4 deaths per 1,000 live births, which is an increase from 7.3 in 2002. The leading causes of death were related to short gestation and low weight birth, complications of labor and delivery and Sudden Infant Death Syndrome. The infant mortality rate is expected to gradually rise largely due to the inability to reduce low weight births.

• While the white infant death rate has declined over the last twenty years, the black infant mortality rate (14.1 per 1,000 live births in 2004) is twice the white rate. Given the increasing number of minority births, this racial gap will continue to widen.

• The perinatal death rate, which is a measure of natural fetal deaths beyond 28 weeks gestation in combination with infant deaths in the first seven days of life) mortality, was 11.7 per thousand live births in 1983, declining overall in 2001 to 6.2. However, it has gradually risen to 6.6 in 2004.

• Contributing factors to the increase in the perinatal mortality rate are (1) increase in the number of uninsured women in Virginia (2) increase number of minority women especially noncitizen residents (3) increase number of women living in poverty and (4) increase number of women unmarried and as head of household.

• Despite advancements in health care and medical technology, the low weight birth rate has continued to steadily increase and is now 8.2 per 1,000 live births. As the population ages, the age of first pregnancies is increasing and parity is decreasing. The use of infertility treatments is increasing and is contributing to this. The number of low weight births is expected to rise and there will be more high-risk infants born needing more intense and costly medical care.

• Sickle cell disease is a genetic disorder that affects the shape and function of the red blood cell. It is the number one genetic disorder identified in the African American population and there are 2,600 Virginians living with this disease. It has been demonstrated that early detection, comprehensive care and the administration of penicillin prophylaxis can greatly reduce the morbidity and mortality in newborns identified with sickle cell disease. Sickle cell disease is changing from a fatal disease of childhood into a chronic disease of adulthood. This shift will create an adult population that will likely experience a higher rate of morbidity from the disease due to the lack of qualified adult providers.

• Any new legislation on the state or federal level could affect the service area customer base, e.g., further restricting the ability of a woman to obtain access to abortion services. The Virginia General Assembly is considering expansion of the BCCEDP. The addition of state funds will expand the current customer base for

BCCEDP. It will allow the program to provide diagnostics to women 18-39 years of age and breast and cervical cancer screening and diagnostics to women 40-49 years of age.

Service Area Products and Services

- Conduct routine needs assessment activities including review and analysis of birth certificate data, hospital discharge data and fetal and infant mortality reviews in order to monitor and describe the status of women's and infants' health in the Commonwealth.
- Identify gaps in services for high-risk populations such as pregnant teens, women experiencing complications of pregnancy or postpartum, or women not receiving the recommended screening and treatment for cancer.
- Develop the capacity to meet customer's needs for reliable, accurate, timely and relevant public health information regarding women's and infants' health.
- Monitor and analyze all proposed legislation that impacts women's and infants' health and make recommendations on action needed.
- Complete legislative studies that address women's and infants' health including pregnancy related issues. Promulgate regulations as deemed necessary to ensure women's health.
- Coordinate with other state agencies to examine policies affecting women's health, including perinatal health, e.g., Department of Mental Health, Mental Retardation, and Substance Abuse Services, Department of Social Services, and Department of Medical Assistance Services.
- Provides technical assistance to other agency staff, legislators and persons in other public and private organizations working to improve women's and infants' health.
- Identify policy issues having an impact on women's and infants' health at community, state, regional, state and national level.
- Provide leadership in developing appropriate policy to address women's and infants' issues in cooperation with internal and external partners.
- Improve the access to care provided to women and infants who would otherwise not obtain needed health care through resource allocation and/or seeking external funding.
- Increase the knowledge of health care professionals who provide direct care services to women and infants through technical assistance, education, providing standards of care and guidelines, and sharing findings from legislative or community needs assessments.
- Provide targeted media campaigns regarding healthy behaviors in order to improve the health of women and their infants.
- Provide resources and/or technical assistance to community-based groups to initiate services for women and infants in need.
- Monitor all program activities to assure the goals, objectives and strategies are based upon data and are being implemented accordingly.
- The Girls Empowered to Make Success (GEMS) program encourages healthy behaviors in siblings of pregnant teens in order to reduce teen pregnancy.
- Maternal death reviews are conducted in collaboration with the Office of the Chief Medical Examiner. All maternal deaths that occur within one year of termination of pregnancy are identified and reviewed by a multidisciplinary team to determine quality of care and the effectiveness of the health care system or strategies can be identified to prevent future deaths.
- Seven Regional Perinatal Councils (RPC), which are state-supported regional coalitions who address perinatal health issues in their locality, provide perinatal provider outreach education

Service Area Products and Services

and conduct Fetal and Infant Mortality Reviews (FIMR).

- The Sudden Unexplained Infant Death Referral Program provides information and counseling for families that have experienced an infant death within one year.
- Partners in Prevention (PIP) funds ten local projects directing activities to reduce nonmarital births in the 20-29 age group, where most of these births occur.
- The 3 P's of Perinatal Depression project educates providers about depression through a Web-based curriculum for which they can earn continuing education credits. The project has the potential to reach 20,000 providers in the 18 month period for which it is funded.
- Loving Steps, the Virginia Healthy Start Initiative, a grant program in three communities with high rates of infant deaths, provides funding for nurse case management, nutrition therapy, lay home visiting, and health education for pregnant women with the goal to reduce infant mortality and morbidity. Local coalitions conduct FIMR and address local issues which are negatively impacting perinatal health.
- Capacity building to improve women's health across the lifespan is accomplished through collaborative efforts with internal and external customers.
- • Breast and Cervical Cancer Early Detection Program (BCCEDP) funds twenty-three competitive contractors to provide cancer screening targeting indigent minority women age 50-64.
- • The Comprehensive Sickle Cell Services Program provides supplemental funding to four centers to diagnose, educate, and case manage children with sickle cell disease as identified through Virginia’s Newborn Screening Program. The Virginia Sickle Cell Awareness Program provides public awareness, provider training, adult screening, and community-based education regarding sickle cell disease.
- • The Family Planning Program funds comprehensive family planning services including services through the local health departments, a variety of contraceptive methods funding for voluntary sterilization of men and women.
- • The Resource Mothers Program funds twenty-six local programs that provide intensive home visiting through lay mentors with the goal to reduce infant mortality and morbidity associated with teen pregnancy.

Factors Impacting Service Area Products and Services

• New areas of need identified by federal agencies may affect funding available and the products and services offered by the division, e.g., grants for mental health.

• Several major grant programs supported by federal funds have fallen out of favor and received only level or reduced funding, have uncertain futures and probably will continue to decrease or be eliminated, e.g., Title V and Title X decreased in 2005.

• Similarly, changes in the scope of services will also change the specific types of products and services provided.

• Rising administrative costs coupled with level funding will mean fewer dollars allocated to direct services and fewer clients served.

• Customer demands for certain products may affect what is offered and how resources are allocated.

• The development of the electronic medical record could completely reshape the way the health department collects personal health indicators.

• An increase in the number of undocumented residents who do not qualify for medical assistance programs will increase demand for services without insurance reimbursement or increased funding.

• The Department of Medical Assistance Services (DMAS) developed policies about benefits and eligibility that affect the availability and quality of care for women and infants, Pregnant women and children enrolled in Medicaid who reside in an area served by a Medicaid Managed Care plan are required to enroll in the plan, which means that Medicaid will only reimburse for services provided by the plan. In order to be reimbursed for services provided to women enrolled in a Medicaid Managed Care Plan, health departments must be meet the managed care plan's provider requirements, which in many cases are too costly and administratively burdensome, and enroll in the network. Furthermore, rates established by the Medicaid managed care plans tend be substantially less than the Medicaid fee-for-service rate. Thus, without the revenue generated from the Medicaid population or the decreased revenue paid by the managed care plans, it has become too costly for many health departments to continue providing maternity clinics.

• Increased technology and improved contraceptive methods are becoming available but not necessarily available to clients in the local health departments because they cost more. This discrepancy has ethical and possible legal implications for not offering the full array of contraceptive methods available.

• Almost half of all pregnancies are unintended among adults and two thirds are unintended in teens with neither using contraceptives or using them effectively.

• Economic decisions of hospitals and providers, including local health departments, to reduce services has restricted access to health care for women and infants.

• Requirements by funding sources for interagency collaboration in order to provide comprehensive services to the family and the child will require increased planning time by providers at the state and local level.

• The health care system continues to be structured to address illness, therefore shifting emphasis to health promotion, early intervention services, and alternative and complementary approaches to prevention and treatment will require a reorganization of funding priorities.

• Second to heart disease, breast cancer is the leading cause of death for women in Virginia. The incidence of breast cancer is increasing in Virginia but mortality is decreasing. There is a 1 in 7 chance that a woman will develop invasive breast cancer during her lifetime; the chances increase particularly for women age 40 and older. A woman's changes of surviving breast cancer are good if she detects the cancer at an early stage. The five-year survival rate is 97 percent for women who detect their cancer in its earliest stage, compared to 23 percent for late-stage cancers. The BCCEDP is only serving about 11 percent of the women who are in need of screening services and cannot expand capacity without further funding.

• Research findings on the causes of premature births, breast and cervical cancer and other diseases and conditions will redirect products and services to new areas. Decoding the Human Genome will play a major role in changing much of what is known about medicine in the form of understanding, prediction, prevention, diagnosis and treatment of disease as well as how health services are funded.

• Data is limited on women affected by depression during pregnancy, but the literature estimates 10-15 percent are affected postpartum, which means about 13,000-19,500 women are affected in Virginia yearly. As community awareness of this disorder increases, there will be increase demand for services, which currently are not adequate in many areas of the state. Mental illness including substance abuse is on the increase.

• Fewer obstetricians, due to malpractice concerns, will put pressure on local health departments, community health centers and free clinics to serve growing numbers of uninsured pregnant women.

Anticipated Changes To Service Area Products and Services

• If Medicaid/Medicare provider reimbursement rates are increased, those programs with level funding and presently using the Medicaid/Medicare fee structure will be required to increase the program payment capitation rates for their contractors/providers which will ultimately result in a reduction in the number of clients served, e.g., BCCEDP and sterilization.

• Comprehensive insurance benefits for women's health are not fully met by government-supported plans; therefore program services are projected not to be able to satisfy the growing demand.

• The adoption of evidence-based medical care should improve the quality of direct services to clients but may increase costs if standards of care are raised. Then again, the use of strictly evidenced-based medicine has the potential to reduce costs if protocols and procedures are only ordered when needed, not based upon defensive medical care practices.

• Integration of community health workers into the Virginia health care delivery system will enhance access by linking families to providers and improve effectiveness of care through patient education and follow-up in the community.

• Continued attempts to limit the ability of a woman to obtain contraception and abortion services are anticipated.

• Federal funding priorities and levels will change the products and services provided.

• More attention will need to be given to addressing the needs of a growing immigrant population who speak different languages, speak little or no English, and have different cultural beliefs, values and health practices.

• Products and services will have to take into account the growing interest in integrating alternative and complementary forms of medicine into traditional health care.

Service Area Financial Summary

The majority of funding in this service area is from federal grants including Title X Family Planning, Breast and Cervical Cancer Early Detection Program, Loving Steps, Perinatal Depression, Partners in Prevention, Girls Empowered to Make Success and Title V Maternal and Child Health Block Grant (Title V MCH). The Title V MCH combined with state funds supports other activities such as the Resource Mothers Program, Regional Perinatal Councils, Virginia Sickle Cell Awareness Program, and Bright Futures Virginia. The Resource Mothers Program also includes funding from Medicaid. Seventy-five percent of the administrative budget comes from the Title V MCH Block Grant with the remaining funds from the state. The administrative funds support salaries for the leadership, policy activities, and two program managers not funded through grants or contracts, and administrative support for the service area. Besides personnel costs, the administrative funds support a variety of activities including general office support, periodic special projects, data collection and analysis, day to day operations, laboratory services for maternity clients in local health departments, state supported abortion services, and staff travel and training. The Comprehensive Sickle Cell Program is exclusively funded through state general funds and provides clinical services for children and their families affected by sickle cell disease. It is anticipated there will be an increase in funds for the BCCEDP and Resource Mothers Program if approved by the 2006 General Assembly.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$1,703,641	$3,146,207	$1,703,641	$3,146,207
Changes To Base	$1,002,746	$521,534	$1,002,746	$521,534
SERVICE AREA TOTAL	**$2,706,387**	**$3,667,741**	**$2,706,387**	**$3,667,741**

Service Area Objectives, Measures, and Strategies

Objective 43005.01

Eliminate barriers to care and increase access to care for women, infants and their families by facilitating systemic changes, developing policies, improving practices, providing direct services and pursuing additional funding.

Improved public health infrastructures, which reduce barriers to care and increase access to women, infants, and their families are necessary in order to improve overall health outcomes. Successful policy development, systemic change facilitation, provider education and training, and the pursuit of additional funding are activities that will greatly support the improvement of the public health infrastructures.

This Objective Supports the Following Agency Goals:

- Collaborate with partners in the health care and human services system to assure access to quality health care and human services.

  (This is also aligned with Virginia's long-term goal of engaging and informing citizens to insure we serve their interests as well as supporting citizens toward healthy lives and strong resilient families.)

This Objective Has The Following Measure(s):

- **Measure 43005.01.01**

  Perinatal mortality rate.

  Measure Type: Outcome **Measure Frequency:** Annually

  Measure Baseline: 7.0 deaths per thousand resident live births in 2003.

  Measure Target: Maintain the rate at no more 7.0 deaths per 1,000 live births by June 2008.

  Measure Source and Calculation:

  This data will be collected annually from the Virginia Center for Health Statistics.

- **Measure 43005.01.02**

  Percentage of clients served who are members of minority populations.

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: As of 2004, 41% of the clients served by this service area were racial and ethnic minorities.

  Measure Target: 46% by June 2008.

  Measure Source and Calculation:

  This measure will be derived by collecting data on participants/clients in the various programs, including family planning, sterilization, Resource Mothers, Loving Steps, maternity, sickle cell programs, and BCCEDP, who provide direct clinical services. The percent of nonwhite clients will be calculated and monitored yearly.

Objective 43005.01 Has the Following Strategies:

- Enhance customer knowledge and use of health care services, especially those aimed at prevention and promotion of healthy behavior, e.g., good nutrition, exercise, avoidance of alcohol, drugs, tobacco and awareness of Bright Futures guidelines for healthcare.
- Conduct policy analysis and planning to facilitate decision-making by policy makers, e.g., review all proposed legislation, analyze bills affecting the work of the division and make recommendations to agency management and the Governor on action to be taken.

- Improve internal linkages and coordination in VDH, enhancing and expanding external relations with other government agencies and private entities to build capacity for systems changes that will improve women's health in Virginia and leverage funds for future initiatives.
- Identify gaps in services and barriers to care as well as identify and address opportunities for community linkages and new partnerships to improve women's and infants' health.
- Update and refine the statistical profile of women, Women's Health Virginia 2004.
- Produce a brochure on women's health status in Virginia for use by employers, health care providers, educators, and various branches of state and local government.
- Provide funding to contractors to encourage pregnant women to receive early and adequate prenatal care.
- Provide funding to contractors to offer case management to pregnant women and infants (birth to age 2 years) who are at high risk due to social, financial and medical risk factors for poor birth outcomes utilizing nurse and/or lay home visitors in the BabyCare, Loving Steps, sickle cell, and Resource Mothers program.
- Provide resources and training to contractors to mentor pregnant teens and reduce morbidity in this population.
- Fund contractors that design initiatives to increase the proportion of very low birth weight infants born at specialty hospitals and subspecialty hospitals.
- Administer grant that provides funding to local health departments to provide comprehensive family planning services.
- Provide breast and cervical cancer early detection services to eligible women ages 40-64, focusing enrollment of never/rarely seen women and minorities through funding to contractors.
- Promote the inclusion of community health workers in health care delivery in order to reach diverse cultural ethnic groups. (RM, BCCEDP)
- Require all contractors to provide weight assessment and initial nutrition counseling for clients in their programs.
- Maintain and develop successful partnerships with those delivering clinical, preventative and community-based services.

Objective 43005.02

Collect, analyze and use objective, evidence-based data and information to improve programs serving women, infants and their families and report health status changes to the providers.

Reliable, quality data and information is essential to the service area fulfilling its public health function of surveillance. It allows the service area to better understand the health status of the population it serves, share this information with customers, and plan and efficiently allocate resources to the areas of greatest need and potential impact.

This Objective Supports the Following Agency Goals:

- Promote systems, policies and practices that facilitate improved health for all Virginians.

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- Maintain an effective and efficient system for the investigation of unexplained or suspicious deaths of public interest.

  (This objective is also aligned with Virginia's long-term goal of engaging and informing citizens to ensure that we serve their interests.)

This Objective Has The Following Measure(s):

- **Measure 43005.02.**

  Number of provider/partner educational activities conducted and number of individuals trained.

  Measure Type: Output **Measure Frequency:** Annually

  Measure Baseline: As of 2004, there were 690 provider/partner educational activities provided yearly with at least 20,000 persons attending. (The number of participants is not unduplicated.)

  Measure Target: Increase the number of trainings to 725 (five percent increase) to at least include 20,000 participants by June 2008.

  Measure Source and Calculation:

  This measure will be calculated on the basis of records of provider/partner educational activities sponsored by DWIH programs and number of people that attended. The figures will be provided by all program managers yearly and summarized on a division spreadsheet. Providers and/or staff in organizations interested in the health of women and infants will be the focus of training activities which will include topics related to the health care of women and infants. The RPCs, BCCEDP, PIP, Resource Mothers, GEMS, VASCAP, the Comprehensive Sickle Cell contractors, Loving Steps, family planning and other educational activities where DWIH staff have been lead in the planning and implementation will be counted. Only those educational activities conducted by contractors within their scope of service will be counted.

Objective 43005.02 Has the Following Strategies:

- Conduct needs assessments, surveys and program evaluations to effect changes and improvements in service delivery and resource allocation.
- Improve data collection systems to enhance the quality and timeliness of information to better reply to customer requests for information.
- Conduct reviews of infant and maternal deaths to identify weaknesses in the system of care and strengthen them, thereby preventing future deaths.
- Design and disseminate social marketing campaigns that encourage women to become healthier (e.g., Loving Steps and Two Words.)